Introduction and Background

This report on the California Plan to Promote Health and Mental Health Equity is the first biennial report of the new Office of Health Equity (OHE), established in 2012 under the California Health and Safety Code Section 13109.5 ("the Code"). The OHE, operating within the California Department of Public Health, is tasked, first and foremost, with aligning state resources, decision making, and programs to achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantages and historical injustice. The overriding objective of the plan, included in this report, is to improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

The Code instructed the Office of Health Equity to seek input from the public on the plan through an inclusive public stakeholder process, and to be developed in collaboration with the Health in All Policies Task Force. This was accomplished through several means, including meetings, webinars, surveys, and other correspondence. An advisory committee was established with a membership of 25 health experts, advocates, clinicians and consumers representing diverse vulnerable communities and vulnerable places, across multiple fields and sectors. The Health in All Policies Task Force was represented on the committee as well. The advisory committee held its first meeting in September 2013. This and all subsequent meetings have adhered to the Bagley-Keene Open Meeting Act ("the Act"), set forth in Government Code sections 11120-111321, which covers all state boards and commissions. Generally, it requires these bodies to publicly notice their meetings, prepare agendas, accept public testimony and conduct their meetings in public unless specifically authorized by the Act to meet in closed session.

The advisory committee meetings held in January, March and May 2014 were largely dedicated to providing input into the development of the plan. At these meetings, there were presentations; full committee discussions; small group discussions involving advisory committee members, OHE staff, and

the public; and formal public comment. Members of the public that were not able to participate on site were able to participate via conference call.

In April and May 2014, statewide webinars were held to introduce initial drafts of the plan, answer questions, receive comments, and allow for polling to establish priorities and partnership interests. A 61-item survey was also made available during that time for more in-depth feedback opportunities. The input from over 60 surveys and several letters was considered in the further development of the plan.

Engagement with the public also occurred through hundreds of meet-and-greets in person and by phone with OHE staff, primarily the Deputy Director, Jahmal Miller. These meetings additionally informed the plan.

California's Human Diversity: Opportunities and Challenges

California's population is the most diverse in the continental United States[1], and one of the most diverse in the entire world. According to the state Department of Finance, the Latino population probably became the state's largest ethnic plurality, at about 39 percent of the population, in March 2014, and it is predicted to approach majority status by 2060 (See Figure tk—Calif population by race/ethnicity 2010 and 2060)[2]. That makes California only the second state in the nation, behind New Mexico, in which whites are not the majority and where Latinos are the plurality. The state's non-Hispanic white population in mid-2014 is estimated to be a fraction of a percent less than the Latino population, at 38.8 percent, down from 57.4 percent in 1990. Whites are trailed by the Asian/Pacific Islander population at 13 percent (up from 9.2 percent in 1990); African Americans at 5.8 percent (down from 7.1 in 1990); and less than 1 percent Native American .

[1] Beyond Diversity Resource Center, Mapping Diversity in the United States, online at www.beyonddiversity.org
[2] California Depart. Of Finance, News Release: New Population Projects, Jan. 31, 2013, online at www.dof.ca.gov/research/demographic/reports/projections/

California's human diversity does not end with race and ethnicity, but includes large shares of other sub-populations relative to other states, including the lesbian, gay, bisexual, transgender, questioning (LGBTQ) community; persons with disabilities; undocumented immigrants; and many others. For instance, according to the 2010 census, California has one of the highest percentages in the nation of married couples of mixed race or ethnicity, and is among the leading states in the number of same-sex households[3].

Diversity's Many Benefits. . .

This diversity has been a source of great strength for the state's economy and cultural life, enriching California's schools, universities, communities, and industries with a kaleidoscope of skills, knowledge, and determination to succeed. More than 1 in 3 small business owners in California is an immigrant, according to an analysis of census data by the New York-based Fiscal Policy Institute. Close to half of all small businesses in Los Angeles are owned by immigrants, who make up about 34 percent of the city's population. Statewide, almost one-third of the state's 3.4 million small businesses are owned by people of color[4]. And as consumers, Latinos alone accounted for an estimated $1.2 trillion in purchasing power nationally in 2012, a market larger than the entire economies of all but 13 countries[5] .

Immigrants also make up 38.3 percent of all science, technology, engineering, and math graduates at the state's most research-intensive universities and account for 56.5 percent of the state's engineering PhDs[6]. A recent study from the University of California, Irvine, of the counties of Orange, Los Angeles,

[3] U.S. Census Bureau, Households and Families, 2010 issued April 2012, at http://www.census.gov/prod/cen2010/briefs/c2010br-14.pdf

[4] Small Business Administration, "California Small Business Profile," February 2011. http://www.sba.gov/sites/default/files/files/ca10.pdf

[5] Selig Center for Economic Growth, The Multicultural Economy, 2013, Terry College of Business, University of Georgia, 2013, online at http://www.terry.uga.edu/news/releases/hispanic-consumer-market-in-the-u.s.-is-larger-than-the-entire-economies-of#http://www.terry.uga.edu/news/releases/2010/minority-buying-power-report.html

[6] The White House, The Economic Benefits of Fixing Our Broken Immigration System: Impacts for California Families, citing data from Partnership for a New American Economy's "Map the Impact" project. Online at http://www.whitehouse.gov/sites/default/files/docs/state-reports/The%20Economic%20Benefits%20of%20Fixing%20Our%20Broken%20Immigration%20System_California.pdf

Riverside, San Bernardino, and Ventura looked at interrelationships among changing community factors such as racial and ethnic demographics, employment and economic welfare, housing density, crime and public safety, and land use. It found positive signs of change along all dimensions, especially rising property values in formerly homogenous neighborhoods that have become ethnically mixed due to recent Latino and Asian immigration, reversing the trend of the 1980s and 1990s[7].

. . .And Many Challenges

Despite these strengths, the state's growing human diversity also has a darker side, one that represents a great threat to California's future. This is the persistent, unjustifiable state of inequities in various social, economic, and environmental conditions that result in gaping disparities in the health of vulnerable populations and places, especially low-income families and neighborhoods and communities of color.

In many instances, these disparities in health status are a matter of life and death, as in differences in life expectancy and death rates among the state's major racial and ethnic groups (See Figures TK and TK – (age-adjusted death rates by r/e 202-10 and Life expectancy by R/E, 2006-2008). The state's average life expectancy of 80.1 years in the 2006-2008 period masked a nearly 13-year gap between Asian Americans, at 86.1 years of life expectancy, and African Americans, at 73.3 years. And while the state's death rates have been steadily declining for almost all racial and ethnic groups, a similar disparity persists for African Americans relative to Asians and other sub-populations as of 2010. Life expectancy can also relate to the social and environmental conditions of place -- where one lives, works, learns, and plays: Residents of high-income San Francisco, for instance, outlive those in the lower-income Riverside-

[7] Southern California Regional Progress Report, 2012, Metropolitan Futures Initiative, School of Social Ecology, U.C. Irvine, June 14, 2012.

San Bernardino area by three years, 81 years to 78[8]. In Oakland, Calif., an African American child in the low-income flatlands will on average die 15 years earlier than a white child who lives in the affluent hills[9].

Similar gaps among population groups exist for numerous chronic health conditions that drive the disparities in death rates. Although death rates from stroke have declined in almost all racial and ethnic groups, the rate among African Americans remains about 50 percent higher than some other racial or ethnic groups, mirroring similar disparities in related risks for high blood pressure, diabetes, high cholesterol, tobacco use, and obesity[10]. Hospitalization rates for asthma, which correlate with such socioeconomic factors as low income and exposure to poor air quality, are more than three times as high for African Americans as for most other racial or ethnic groups[11].

Disparities in health risks are also common within sub-populations, especially those designated by large geographic areas of origin, such as Latinos and Asian/Pacific Islanders. For instance, significant gaps in rates of colorectal cancer exist among Japanese, Korean, Vietnamese, Chinese, Filipino, and South Asian Californians[12].

[8] Carolilne Peck, Julia Logan, Neil Maizlish, Jason Van Court, The Burden of Chronic Disease and Injury, California 2013, California Dept. of Public Health, Center for Chronic Disease Prevention and Health Promotion, 2013.
[9] Alex Desautels, Kim Gilhuly, and *Tammy Lee, How a Public Health Department Can Advance Health Equity Through Policy Change, Health Impact Partners, January 28, 2013
[10] Caroline Peck, et al, op. cit.
[11] Ibid.
[12] Ibid.

What Drives Health Disparities?

One way of looking at the causes of health disparities is to examine the factors that produce and maintain healthy individuals, communities, and places. Many people assume that health is mostly a function of individuals seeing the doctor regularly for good medical care and avoiding known unhealthy behaviors, such as not exercising and smoking. But most public health experts have adopted a model of the determinants of health and health disparities that views individual health status and medical interventions, including the clinical care individuals receive, as the proximate "downstream" determinants of health outcomes.

In this model, these downstream contributors to health are causally related to "midstream" health determinants, such as people's genetic and biological makeup and individual health behaviors, such as smoking. And they are even more remotely but powerfully influenced by a host of population-level environmental, social, and economic factors further "upstream" that the World Health Organization has defined as "the conditions in which people are born, grow, live, work and age. These circumstances," declared WHO, "are shaped by the distribution of money, power and resources" within every level of society,[13] resulting in significant upstream health inequities and downstream health disparities that disproportionately impact low-income populations, communities of color, and other groups that are subject to racism and discrimination.

(Suggest illustration of downstream-midstream-upstream health determinants here)

While public health researchers have differed on the relative importance of these various upstream to downstream health determinants, it is estimated that medical care, healthy behaviors, and genes and

[13] World Health Organization, What Are the Social Determinants of Health, online at http://www.who.int/social_determinants/sdh_definition/en/, updated May 7, 2013.

biology all together account for only about half of a society's overall health outcomes[14], even though these downstream determinants attract the lion's share of health funding and expenditures.

The Social Determinants of Health

What constitutes the other 50 percent of the determinants of health and well-being is a complex interplay of environmental conditions, such as air and water quality; the quality of the constructed built environment (housing quality, mixed land use, public transportation options, safe streets, parks and playgrounds, safe workplaces, etc.); and a whole host of socioeconomic factors. These latter include opportunities for employment, income, early childhood development and education, access to healthy foods, health insurance coverage and access to health care services, neighborhood safety from crime and violence, culturally and linguistically appropriate services in all sectors, protection against institutionalized forms of racism and discrimination, and public and private policies and programs that prioritize individual and community health in all actions.

Significantly, in contrast to the individual-level downstream determinants, these environmental and socioeconomic determinants have population-level impacts. Understanding this is vitally important for designing and implementing upstream health interventions, such as economic development programs in low-income communities, which can be targeted on specific sub-populations, communities, and neighborhoods, thus affecting thousands or tens of thousands of people rather than one individual at a time.

When a society's principles and policies work to optimize these interrelated social determinants of health on the basis of fairness and equity for everyone, health is created at the level of the individual,

[14] Minnesota Department of Health, Advancing Health Equity in Minnesota: Report to the Legislature, February 1, 2014.

the community, the environment, and society at large (See Fig. TK -- create graphic similar to "Achieving Health and Mental Health Equity at Every Level" in April 16 OHE webinar). When any combination of these drivers is lacking, the engine that powers total health can break down, resulting in significant health inequities and disparities in health outcomes. Understanding what creates or limits the opportunity for health is essential for understanding what creates disparate health outcomes and what needs to be done to prevent them.

The Deep Roots of Health Inequities

Unfortunately, while America's constitutional principles may define a society dedicated to fairness and equity, its policies have often lead in the opposite direction, especially as regards the creation of opportunities for building household wealth. And as the poet Ralph Waldo Emerson wrote, "The first wealth is health."

That saying has recently been revised to make the point that "wealth equals health," a point forcefully driven home in the 2008 PBS documentary "Unequal Causes: Is Inequality Making Us Sick." That widely viewed program closely examined how household wealth in the United States serves as the major determinant of health and health inequities, influencing virtually all other upstream environmental and socioeconomic factors, including education, employment, housing, childcare, recreational opportunities, food supply, health care access, and neighborhood safety and environmental quality.

If health is wealth, it follows that efforts to understand and reverse the drivers of health inequities need to begin by looking at how the policies and actions of private institutions and governments have contributed to the large gaps in wealth that mirror the gaps between the healthy and the unhealthy.

Behind the Gaps in Wealth and Health

Historically, the long eras of slavery and outright discriminatory policies in housing, education, transportation, and economic development largely excluded people of color and other minorities from the formal economy, up until the latter half of the 20th century. Many of those official policies ended over the past half century, but their harmful legacies persist even today in numerous, less obvious ways, both officially and unofficially.

For instance, it is widely recognized today that private and public bank lending policies that enabled the sub-prime mortgage practices during the housing boom contributed significantly to the 2007-2009 housing bust, which wiped out vast shares of homeowners' household wealth. The bust affected all but the richest few percent of the population, but had much greater negative impacts on low-income households, especially communities of color. That's because the wealth accumulation among African and Latino families, among other disadvantaged groups, is more recent and more concentrated in home values than for most white families, whose much greater wealth is more broadly distributed over many other kinds of assets than housing, such as stocks and bonds[15].

A recent analysis of annual income surveys by the U.S. Census Bureau revealed that in 2011 – two years into the so-called "recovery period" from the Great Recession -- average African American and Latino households owned only six and seven cents, respectively, for every dollar in wealth held by the average white family. In 2011, the median net worth of households of color had fallen from 2005 levels – before the recession – by 58 percent for Latinos, 48 percent for Asians, 45 percent for African-Americans, but only 21 percent for whites (Housing value declines were sharply steeper in California). The same study

[15] Shapiro, Thomas, et al, The Roots of the Widening Racial Wealth Gap: Explaining the Black-White Economic Divide Institute on Assets and Social Policy, Brandeis University, Feb. 2013, online at http://iasp.brandeis.edu/pdfs/Author/shapiro-thomas-m/racialwealthgapbrief.pdf

found that the average liquid wealth – meaning cash on hand or assets easily converted to cash – of white families was 100 times that of African Americans and more than 65 times that held by Latinos[16].

(See http://cdph.ca.gov/programs/Documents/BARHII-Presentation-Sandi-Galvez.pdf for slide graph on Median Net Worth of Households, by race, from Pew Research, for possible reproduction and use here)

The study, from Brandeis University, also examined the significant growth of the wealth gap for African American families over a 25-year period (1984-2009) and concluded that it could be largely explained by five factors: years of homeownership, household income, unemployment, education, and inheritance, all of which are deeply influenced by local, state, and federal policies that create either opportunities or barriers to wealth, and health.

The bad news from the evidence is that public and private policy is a major factor in the persistence and growth of a widening American wealth gap, which is a key driver of health inequities among low-income families, communities of color, women, children, and other vulnerable populations. The good news is that policies are not carved in stone. They can be reshaped to address and limit those same inequities in the drivers of both wealth and health.

Health in All Policies

One of the most potent approaches to shaping effective public and private policies for the promotion of health and health equity is what is known as "health in all policies." The American Public Health Association describes this approach as "a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas[17]."

[16] Ibid

[17] Health in All Policies: A Guide for State and Local Governments, American Public Health Association, Public Health Institute and the California Department of Public Health, online at http://www.apha.org/programs/cba/CBA/health_all_policies?utm_source=Webinar:+Policy&utm_medium=Email&utm_campaign=Health+in+all+policies+release

That may sound pretty ineffectual at first glance. But consider what could happen if every time a government agency developed or revised or implemented a new program – a new highway, a housing finance plan, an educational program, a regulatory plan for power plants, agricultural subsidies, etc. – it had to seriously consider all the ways in which that program could potentially affect the health, equity, or sustainability of the places and the people whose lives could be impacted by that program. In effect, health in all policies amounts to outfitting policy makers with health-tinted lenses that help ensure that the policy decisions they make have a neutral or beneficial impact on the whole wide range of environmental and socioeconomic health determinants.

Health in all policies is based on the recognition that the greatest health challenges – including the health inequities described in this report – are highly complex and often interrelated. Because public health does not have authority over many of the policy and program areas contributing to health inequities, such as transportation, housing, or tax policy, solutions to these complex and urgent problems require working collaboratively across many sectors to address the social determinants of health.

Health in all policies builds on public health's long and successful tradition of collaboration among government sectors, such as implementing fluoridated tap water policies, reducing occupational and residential lead exposure, restricting tobacco use in workplaces and public spaces, improving sanitation, and requiring use of seatbelts and child car seats[18]. Health in all policies takes the idea of cross-sector collaboration further by formalizing ways to systematically incorporate a health, equity, and sustainability lens across the entire government apparatus. What's more, it adds important co-benefits to the primary objective of promoting health and equity: It also supports collaboration across multiple

[18] Rudolph, L, et al, Health in All Policies: Improving Health through Intersectoral Collaboration, Institute of Medicine, September 18, 2013. Online at http://iom.edu/~/media/Files/Perspectives-Files/2013/Discussion-Papers/BPH-HiAP.pdf

sectors; it benefits multiple partners; it engages stakeholders; and it creates positive structural or process change[19].

For these reasons, the health in all policies approach has been embraced by the World Health Organization, the American Public Health Association, the Association of State and Territorial Health Officers, the National Association of County and City Health Officers, and other professional public health organizations. It is being implemented in a variety of ways across the United States, including playing a prominent role in California's Strategic Growth Council and the California Department of Public Health's new Office of Health Equity.

The Case for Addressing Health Inequities

Almost 70 years ago, both the then- new World Health Organization and the United Nations broadly defined health as a basic human right. The WHO Constitution defines the right to health as "the enjoyment of the highest attainable standard of health," including the right to healthy child development; equitable dissemination of medical knowledge and its benefits; and government-provided social measures to ensure adequate health[20]. The Universal Declaration of Human Rights in 1948 declared in Article 25 that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family (sic), including food, clothing, housing and medical care and necessary social services[21]." More recently, the focus on health disparities received a boost in 1998 when the Clinton Administration launched the Racial and Ethnic Health Disparities Initiative. Subsequently, Healthy People 2010 and 2020 moved beyond the traditional research paradigm of merely documenting the health inequities of vulnerable populations by incorporating a commitment to

[19] Ibid
[20] World Health Organization, Constitution of the World Health Organization, 1948.
[21] United Nations, Universal Declaration of Human Rights., 1948, online at http://www.un.org/en/documents/udhr/

actually "achieve health equity, eliminate disparities, and improve the health of all groups" as one of its four overarching goals[22].

The case for viewing health and health equity as an issue of basic social justice has grown ever stronger as researchers and policy experts have learned more about the social and economic impacts of historic and continuing health disparities as they impact the nation's large and growing vulnerable populations. In a nation that defines itself as a land of opportunity, what could of greater moral importance than the opportunity to pursue a healthy life, especially for those populations that are most subject to documented social and institutionalized injustice?

The Costs of Health Disparities

The moral case for addressing health disparities is buttressed by a strong economic argument, which links health equity to the nation's economic competitiveness. Health spending accounted for 17.7 percent of GDP in the United States in 2011, by far the highest share in comparison to the 34 developed nations of the Organization for Economic Cooperation and Development (OECD), and more than 8 percent higher than the OECD average of 9.3 percent. The United States spent $8,508 per capita on health in 2011, two-and-a-half times more than the OECD average of $3,339, while lagging most developed nations in key measures of health outcomes[23].

What share of that excess U.S. spending is attributable to the cost of health disparities is a complex issue, but one widely reported study in 2011 put the direct costs at $230 billion[24]. Adding in the indirect cost of lower workplace productivity due to premature death and illness associated with health

[22] Healty People 2020, Overarching Goals, U.S. Dept. of Health and Human Services, online at http://www.healthypeople.gov/2020/about/default.aspx

[23] OECD, OECD Health Data: How Does the United States Compare?, online at http://www.oecd.org/unitedstates/Briefing-Note-USA-2013.pdf

[24] LaVeist, T. A., D. Gaskin, and P. Richard. 2011. Estimating the economic burden of racial health inequalities in the United States. International Journal of Health Services 41(2):231-238.

disparities added another $1 trillion. That totals almost half of total U.S. health expenditures in 2012. Meanwhile, spending on public health and health prevention, the primary programs for addressing health disparities, accounts for roughly 3 percent of total health care spending[25].

These economic numbers, dramatic as they may be, fail to convey the actual human costs of health disparities – lives lost prematurely and lives stunted and scarred by debilitating ill health, both physical and mental. It may be impossible to objectively assess the full dimensions of the human tragedy of health inequities and disparities, but the cost in mortalities, alone, is revealing. According to a well regarded 2011 study[26], nearly three-quarters of a million U.S. adult deaths in 2000 were attributable to just five of the leading social determinants of health:

- Low education accounted for 245,000;
- Racial segregation accounted for 176,000;
- Low social supports accounted for 133,000;
- Income inequality accounted for 119,000, and
- Area-level poverty accounted for 39,000.

Morally, economically, and socially, neither the United States nor its most humanly diverse state, California, can afford to pay these costs. What we are sacrificing is not only our foundational principles of equal opportunity and equity, but the health and well-being of the very populations that already constitute the majority of Californians and that will increasing represent the strength of the nation's

[25] American Public Health Association, Prevention and Public Health Fund, online at http://www.apha.org/NR/rdonlyres/3060CA48-35E3-4F57-B1A5-CA1C1102090C/0/APHA_PPHF_factsheet_May2013.pdf

[26] Galea S, et al., Estimated deaths attributable to social factors in the United States. Am. J Public Health, 2011 Aug;101(8):1456-65. Epub 2011 Jun 16. At http://www.ncbi.nlm.nih.gov/pubmed/21680937

workforce and the lion's share of its taxpayers. In short, investing in the elimination of health disparities and the creation of health security for all is vital to creating the kind of future we all want for our children and grandchildren.

Creating Health Equity in California: The Office of Health Equity

California's multifaceted efforts to reduce or eliminate health and mental health disparities among California's vulnerable communities reached a major milestone in 2012 with the creation of the Office of Health Equity (OHE), operating within the state's Department of Public Health.

The OHE was created to build upon the existing network of public and private sector partnerships in all economic, social, and environmental sectors that influence health and health care, and to align all state resources, decision-making, and programs to accomplish the following objectives:

- achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice;
- work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;
- advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and
- improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

To carry out its missions, the OHE has been organized into three operational units:

- the Community Development and Engagement Unit,

- the Policy Unit, and
- the Health Research and Statistics Unit, as described below.

The Community Development and Engagement Unit (CDEU)

The CDEU is responsible, primarily, for carrying on the ambitious work of the **California Reducing Disparities Project (CRDP**), launched in 2009 to improve and increase access, quality of care, and positive outcomes in mental health for racial, ethnic, and culturally disadvantaged communities.

Since its creation, the Project has provided funding for the development of separate strategic plans for identifying and reducing mental health disparities among five target populations: African Americans; Asian/Pacific Islanders; Latinos; the lesbian, gay, bisexual, transgender, questioning community; and Native Americans.

The implementation and evaluation of local-level policy interventions recommended in these strategic plans will ultimately serve in the development of a single, comprehensive strategic plan that brings together the evidence-based lessons and successful strategies of each of the population-specific plans, including any similarities among them. This multi-year project aims to provide the state's mental health system with community-identified strategies and interventions that will result in meaningful, culturally and linguistically competent services and programs that meet the unique needs of the five target populations.

A closely related initiative, also supported by the Community Development and Engagement Unit, is the **California Mental Health Services Act Multicultural Coalition (CMMC),** whose primary goal is to promote cultural and linguistic competence throughout the mental health system. The coalition, launched in 2010, is made up of 30 nongovernment employee members representing diverse

multicultural perspectives on mental health, including those that have not been adequately represented in other efforts. Its work will be clearly reflected in the comprehensive CRDP Strategic Plan.

Finally, the CDEU also monitors and supports ongoing implementation of the Bilingual Services Act of 1973, which requires state agencies to provide translated materials in so-called "threshold languages," or those languages used as the primary language by a given number or fraction of a program's beneficiaries.

The OHE Policy Unit

The primary work of the Policy Unit includes staff facilitation for the Health in All Policies Task Force (HiAP), which was created by Executive Order S-04-10 in 2010 and placed it under the auspices of the Strategic Growth Council (SGC). The Task Force is made up of 19 state agencies, departments, and offices and is charged with identifying priority programs, policies, and strategies to improve the health of Californians while also advancing the goals of the SGC.

Task Force members are engaged in an intensely collaborative and creative process to promote innovative strategies to improve health, equity, and sustainability. In recognition of the strong role that local governments play in supporting healthy communities, the Task Force has focused on the unique role that state agencies play in supporting local action. The successes of the Task Force have included broad and concrete changes in state policy and programs, as well as growing collaboration across all government sectors and among communities and decision-makers throughout California.

In 2010-2011, the Task Force gathered input through public workshops, key informant interviews, and written public comment, and used a multi-agency consensus process to develop 34 recommendations of programs, policies, and strategies for state government action to improve health, equity, and sustainability. Criteria for prioritization included health impacts, links to SGC sustainability goals,

feasibility, and multi-agency collaboration. In 2012, Task Force members created implementation plans that outline specific action steps to support the Task Force's near-term priority recommendations. Task Force members are currently engaged in an ongoing collaborative process to carry out those action steps, explore new and emerging opportunities, and renew commitments as appropriate. For more detailed information about the work of the Task Force, see Appendix A.

Health Research and Statistics Unit

The Health Research and Statistics Unit (HRSU) is the technical backbone of OHE, providing and sharing research and data for OHE reports as well as baseline information for programs aimed at eliminating health and mental health inequities in California.

The unit inventories and organizes the abundant information regularly collected by other California Department of Public Health programs, state agencies, research organizations, and community-based organizations on the demographics and geography of vulnerable populations and inequities in health and mental health outcomes, health services, and social determinants of health. It also collects existing information on interventions to reduce health and mental health inequities. This allows numerous stakeholders to rapidly access such information.

The unit also is responsible for synthesizing and analyzing data to provide this report and subsequent biennial statistical profiles of health and mental health inequity in California, thereby providing a baseline against which progress can be measured. This information builds on the expertise of other Department of Mental Health programs, including the Let's Get Healthy California Task Force and the Health in All Policies Task Force's Healthy Community Data and Indicators Project, and the Strategic Growth Council's Regional Progress Report. In addition, the unit analyzes and tracks Healthy People 2020 targets in order to monitor the state's progress in eliminating health and mental health disparities and achieving health equity for all Californians.

Definition of Terms:

- **Determinants of equity:** means social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.
- **Health equity:** means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.
- **Health and mental health disparities:** means differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.
- **Health and mental health inequities**: means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.
- **Vulnerable communities:** includes, but is not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities, or combinations of these populations.
- **Vulnerable places:** means places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.